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Expand Home & Community Based Services

Support NP 22223

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Preserve funds for Montana seniors' home, area services

'The Legislature should begin to address the growing demand for Home and Community Based Services - as the governor has - by preserving funding for this program in the state's budget proposal.'

— Bob Bartholomew, AARP Montana State Director

By BOB BARTHOLOMEW

As Congress searches for ways to stimulate the economy at the state level, boosting federal Medicaid funding should be at the top of the list. And the state Legislature would be wise to follow suit by preserving the funding for the Medicaid Home and Community Based Services outlined in the governor's budget. Preserving these funds is a win-win for the state.

Montana is aging at a faster rate than most other states - in fact, it's one of the fastest-aging states in the nation. Overwhelmingly, most residents want to age in place, ideally in their own homes.

A recent survey of AARP members in Montana showed that 70 percent of respondents ranked remaining in their homes as a top concern, and 75 percent said that helping people age in place should be a top legislative priority.

The findings reflect the struggle of many Montanans to find care they can afford in the setting of their choice. Medicaid will pay for nursing home care right away, but those seeking alternatives have to get in line: More than 400 residents are currently waiting for home and community-based services. Some can expect to wait for almost a year.

According to an AARP report released in July, Montana allocates 75 percent of its Medicaid long-term-care funding to nursing homes, despite a decrease in the number of residents in such facilities and the much higher cost of providing care in an institutional setting. More state dollars allocated to home and community-based care would provide more choices in our state's long-term-care system and help meet our citizens' demand for these services.

In addition to providing valuable services to our seniors, Medicaid is a powerful economic force in our state. Leading economists and researchers agree that Medicaid cuts harm the economy, and that increased Medicaid funding boosts local economies and can help prevent our economic crisis from getting worse. That's because for every dollar Montana cuts in Medicaid funding, the state loses $2.13 in federal matching funds.

The 8 percent increase in Medicaid funding to states proposed by congressional leaders (House Resolution 7110), would generate $87.8 million for Montana. That money then flows through the economy, providing jobs, generating tax revenue for both state and local governments

and essentially ends up in the pockets of Montanans.

We believe providing health security for Montanans through the Medicaid Home and Community Based Services program is exactly the kind of economic stimulus America needs in this time of crisis.

The state Legislature would be wise to leverage any additional federal Medicaid funds as a way to boost Montana's economy. At the very least, the Legislature should begin to address the growing demand for Home and Community Based Services - as the governor has - by preserving funding for this program in the state's budget proposal.

Bob Bartholomew of Helena is AARP Montana state director.

Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?

Home and community-based services help people with disabilities stay in their homes while reducing long-term care spending.

by H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington

ABSTRACT: Medicaid spending on home and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings. [*Health Affairs* 28, no. 1 (2009): 262–272; 10.1377/hlthaff.28.1.262]

ENACTED IN 1965 TO PROVIDE HEALTH COVERAGE for impoverished Americans, the Medicaid program quickly became a major source of payment for long-term care (LTC) services for elderly and nonelderly people with disabilities. During the program's first two decades, these services were offered almost exclusively in institutional settings, such as nursing homes and facilities for people with intellectual disabilities. In the mid-1980s, however, states began to offer LTC services to people living outside of institutions, through what are known as Home and Community-Based Services Waiver programs and Personal Care Services (PCS) Optional Benefit programs. These two programs, plus the smaller Medicaid Home Health Benefit, are collectively referred to as Medicaid home and community-based services (HCBS); all such programs may offer personal assistance that enables people who need help in performing daily activities to continue to live and thrive in the community, instead of being forced to relinquish their independence and move into an institution.

Pressured by advocates for people with disabilities and the elderly, and com-

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pelled by the Supreme Court's 1999 *Olmstead* decision to offer services in "the most integrated setting" appropriate to the person's needs, many states have created or expanded HCBS programs, offering an alternative to institutionalization for millions of poor or near-poor Americans.[1] As a result, HCBS spending has constituted a steadily increasing share of Medicaid LTC costs, rising at a much more rapid rate than spending on institutional services.[2] The estimated $35.2 billion spent on HCBS in 2005 amounts to 37.2 percent of the $94.5 billion national Medicaid LTC expenditure, or 11.7 percent of the $300.3 billion total Medicaid expenditure.[3] A decade earlier, HCBS spending accounted for only 19.2 percent of Medicaid LTC spending and 6.3 percent of all Medicaid spending.[4]

Although states still spend much more on institutional than noninstitutional LTC, the expansion of HCBS programs has nonetheless been blamed for the overall growth in LTC spending. Opponents of further expansion in HCBS have recently used the continued growth in overall LTC spending to argue that noninstitutional LTC services are not cost-effective, in the sense that they increase rather than reduce overall expenditures.[5]

This paper explores the question of whether states that offer extensive HCBS programs experience greater or lesser growth in Medicaid LTC spending than states in which institutional LTC continues to predominate. We are aware of no similar analyses, although one study compared LTC spending in three states that were offering extensive HCBS with projections of spending in the absence of such programs, and concluded that those states had greatly reduced their spending.[6]

The main issue is not the cost of services per person served. A recent study found that the average total public expenditure on a recipient of HCBS waiver services (who must meet the eligibility criteria for institutionalization) was about $44,000 less per year than for a person receiving institutional services.[7] Indeed, waiver programs are required to demonstrate cost-neutrality, in that the per participant spending under the waiver cannot exceed the state's estimate of the costs for the same people had they entered institutions.

Instead, the concern is with the aggregate cost, which may grow if increasing numbers of eligible people are served. There is a fear that the introduction of HCBS programs would create a "woodwork effect," in which large numbers of people who previously received help from family members and did not seek institutional services might sign up for the more desirable noninstitutional services, thus increasing the overall costs. The impact of HCBS programs on aggregate Medicaid spending has been studied in several demonstration projects, but results have been inconclusive.[8]

Data Sources And Methods

■ **Sources.** State data on Medicaid LTC spending for fiscal years 1995–2005 were obtained from reports submitted by state Medicaid agencies to the Centers for Medicare and Medicaid Services (CMS). States report both institutional spending,

for services provided in either nursing homes or so-called intermediate care facilities for people with mental retardation (ICF/MR), and noninstitutional spending, for services provided through waiver, personal care, and home health programs. Data on nursing home, ICF/MR, personal care, and home health spending were obtained from CMS 64 reports, as compiled annually by the Medstat Group.[9] Data on HCBS waiver spending, by type of waiver, were obtained from CMS 64 reports on individual waiver programs, occasionally corrected with data obtained from CMS 372 reports.[10]

Because spending patterns, including the proportion devoted to HCBS, differ markedly according to the targeted population, we analyzed spending explicitly directed toward people with mental retardation and other developmental disabilities (MR/DD) separately from those primarily directed toward people with other types of disabilities. ICF/MR spending and MR/DD waiver spending are classified as MR/DD spending, while nursing home, non-MR/DD waiver, personal care, and home health spending is classified as non-MR/DD spending.

■ **Data limitations.** Limitations in these data include occasional incomplete or inaccurate reporting and expenditures reported according to the date of payment rather than the date of service provision, causing year-to-year fluctuations when states delay payment and shift expenditures to the next fiscal year. Furthermore, a limited amount of spending on services provided under capitated managed care programs is not reported; this limitation is mostly an issue for Arizona, which we excluded from the analysis because the bulk of its expenditures are not listed. A few states (most notably Texas) have or had relatively small "frail elderly" programs distinct from the noninstitutional services already mentioned; because data for these programs are available from the Medstat compilations for some years but not others, we omitted these programs from the analysis, too.

In a few cases of missing or incomplete waiver data for particular waivers or states, we interpolated or extrapolated to estimate expenditures. In one case of a suspiciously large expenditure followed by a negative reported expenditure in the subsequent year, we replaced both numbers with their average.

■ **Facilitating comparisons.** To facilitate comparison across states, we obtained per capita (not per recipient) expenditures for each state by dividing the reported spending by the Census Bureau's population estimate for the state for the given year.[11] To further facilitate comparison across years, we adjusted the per capita spending for inflation in medical care costs, using the Consumer Price Index (CPI) for medical care services; amounts shown are in 1995 medical care dollars.[12]

■ **Classification process.** We then classified states according to their level and pattern of HCBS spending. First, we divided the states into two groups according to the proportion of their total 2005 LTC spending devoted to HCBS. States that spent less than the median proportion on HCBS were classified as low-HCBS states; the remaining states were classified as high-HCBS states. The latter were further divided into two categories according to whether their HCBS spending remained rela-

tively stable or increased markedly during the decade of interest: states whose per capita, inflation-adjusted HCBS spending more than doubled during 1995–2005 were classified as expanding-HCBS states; the remaining states, as established-HCBS states. States that were pioneers in offering extensive noninstitutional services fell into this latter group.

The classification process was done twice, once for non-MR/DD spending and once for MR/DD spending. Thus, two separate groupings of states were obtained (Exhibit 1).

Study Findings

■ **Non-MR/DD spending.** The high- and low-HCBS states (as differentiated according to their 2005 expenditures) differed markedly in the types and amounts of spending on the non-MR/DD population (Exhibit 1). Low-HCBS states spent only about $14 per capita on HCBS in 1995, compared to more than $24 for the high-HCBS states. Both groups of states increased their HCBS spending over the decade much faster than the rate of inflation, with the low-HCBS states increasing by 56.7 percent and the high-HCBS states growing still faster, by 110.0 percent.

HCBS spending data reveal vastly different rates of growth for the established- and expanding-HCBS states (Exhibit 2). Established states increased their HCBS spending relatively modestly during the period (21.2 percent), while expanding states increased their spending by 276.2 percent. Especially rapid HCBS growth is apparent among the expanding states during 2000–2005, mostly because of program growth but also because California shifted a state-only program to a Medicaid personal care plan in 2001.

Nursing home spending grew by 3.4 percent in the low-HCBS states over the period, after adjusting for inflation, but declined by 15.3 percent in the high-HCBS states (Exhibit 3). A pattern of substantial growth is apparent in the low-HCBS states between 1997 and 2002 (followed by a sharp one-year decline, which we hypothesize is attributable to state budget shortfalls), and a steady decline is apparent for the high-HCBS states beginning in 2002.

Total LTC spending on the non-MR/DD population grew by similar amounts in the low- and high-HCBS states (Exhibit 4). But when we compared established and expanding HCBS states, we found that LTC spending actually declined by 7.9 percent in the established-HCBS states, but increased markedly in the expanding-HCBS states (24.2 percent). Spending increased greatly in both the low- and expanding-HCBS states during 1997–2002, when the established-HCBS states were able to hold their LTC spending relatively constant. The established-HCBS states also experienced a large decline in spending between 2003 and 2005, which is not seen in the data from the other states.

■ **MR/DD spending.** Also shown in Exhibit 1 is HCBS and institutional spending targeted to the MR/DD population. The practice of deinstitutionalizing this population, or avoiding institutionalization entirely, is much better established than

EXHIBIT 1
Mean Per Capita, Inflation-Adjusted Medicaid Long-Term Care (LTC) Spending In States With High And Low Home And Community-Based Services (HCBS), By Type Of Expenditure, And Percentage Change, Fiscal Years 1995 And 2005

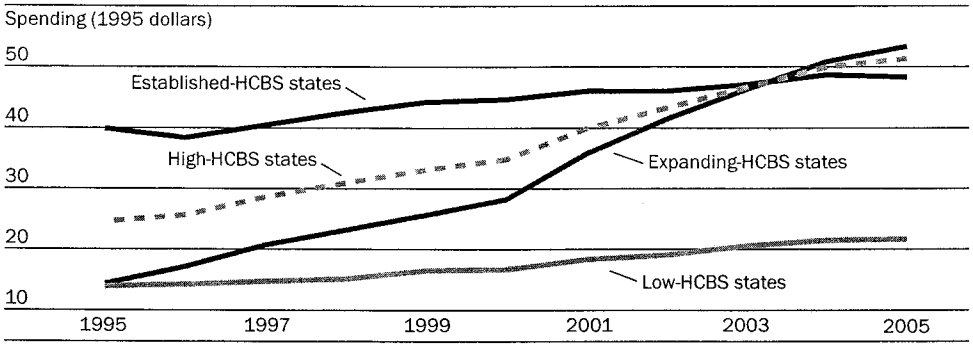
Non-MR/DD spending	Low-HCBS states[a]	High-HCBS states		
		All	Established[b]	Expanding[c]
HCBS spending				
FY 1995	$13.69	$24.35	$39.67	$14.12
FY 2005 (1995 $)	$21.46	$51.10	$48.09	$53.12
Change	56.7%	110.0%	21.2%	276.3%
Institutional spending (nursing homes)				
FY 1995	$122.64	$110.83	$138.54	$92.35
FY 2005 (1995 $)	$126.85	$93.88	$116.03	$79.12
Change	3.4%	−15.3%	−16.3%	−14.3%
Total LTC spending				
FY 1995	$136.34	$135.17	$178.21	$106.47
FY 2005 (1995 $)	$148.31	$144.99	$164.12	$132.24
Change	8.8%	7.3%	−7.9%	24.2%
HCBS proportion of total				
FY 1995	10.0%	18.0%	22.3%	13.3%
FY 2005	14.5	35.2	29.3	40.2

MR/DD spending	Low-HCBS states[d]	High-HCBS states		
		All	Established[e]	Expanding[f]
HCBS spending (MR/DD waivers)				
FY 1995	$14.21	$28.89	$47.82	$18.24
FY 2005 (1995 $)	$36.31	$59.49	$71.04	$52.99
Change	155.6%	105.9%	48.6%	190.4%
Institutional spending (ICF/MR)				
FY 1995	$42.44	$24.81	$26.73	$23.72
FY 2005 (1995 $)	$36.33	$11.93	$10.30	$12.86
Change	−14.4%	−51.9%	−61.5%	−45.8%
Total LTC spending				
FY 1995	$56.65	$53.70	$74.55	$41.97
FY 2005 (1995 $)	$72.64	$71.42	$81.34	$65.84
Change	28.2%	33.0%	9.1%	56.9%
HCBS proportion of total				
FY 1995	25.1%	53.8%	64.1%	43.5%
FY 2005	50.0	83.3	87.3	80.5

SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services 64 and 372 reports.
NOTES: MR/DD is mental retardation/developmental disability. ICF/MR is intermediate care facility for mental retardation.
[a] AL, CT, DE, FL, GA, HI, IN, IA, KY, LA, MD, MI, MS, NE, NH, NJ, ND, OH, PA, RI, SC, SD, TN, UT.
[b] AR, CO, ME, MA, MT, NY, OR, VA, WV, WI.
[c] AK, CA, ID, IL, KS, MN, MO, NV, NM, NC, OK, TX, VT, WA, WY.
[d] AK, CA, CT, ID, IL, IN, IA, KY, LA, MI, MO, NV, NJ, NY, NC, ND, OH, OK, PA, SC, TN, TX, UT, VA.
[e] CO, MA, NH, OR, RI, SD, VT, WA, WY.
[f] AL, AK, DE, FL, GA, HI, KS, ME, MD, MI, MN, MT, NE, NM, WV, WI.

for people with other types of disabilities, and even the low-HCBS states devoted, on average, half of their 2005 MR/DD LTC spending to noninstitutional services. Both the low- and high-HCBS states more than doubled their HCBS spending over the period; this spending nearly tripled among the expanding-HCBS states. Institu-

EXHIBIT 2
Mean Per Capita, Inflation-Adjusted Spending On Home And Community-Based Services (HCBS), Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, In States With Low And High HCBS, Fiscal Years 1995–2005

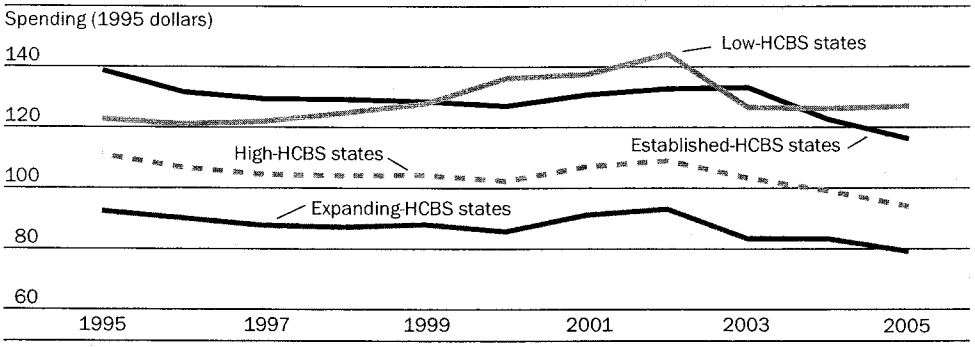


SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.
NOTE: For explanation of types of HCBS states, see text.

tional spending dropped for both low- and high-HCBS states, after adjusting for inflation, but the drop was much more dramatic for the high-HCBS states, where ICF/MR spending declined by more than half, compared to a 14.5 percent drop among the low-HCBS states. Particularly impressive is the 61.5 percent drop in ICF/MR spending among established-HCBS states.

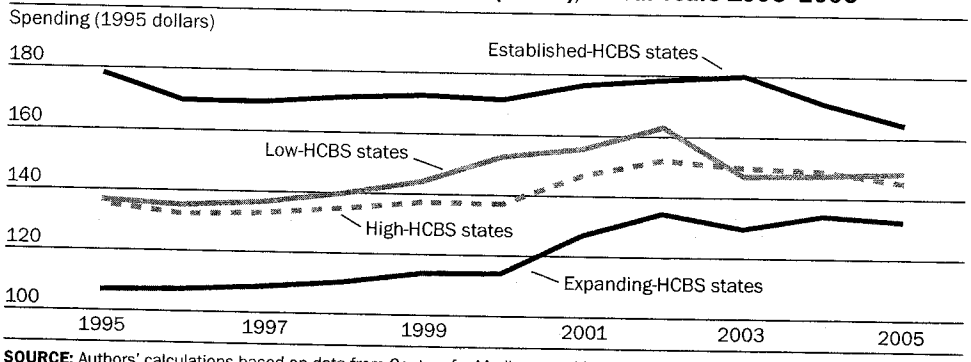
Total LTC spending for the MR/DD population increased for all types of states, with a 28.2 percent increase among low-HCBS states and a 33.0 percent increase among high-HCBS states (Exhibit 5). Established-HCBS states, however, experienced by far the lowest rate of growth (9.1 percent), with hardly any growth in inflation-adjusted spending between 1998 and 2005. Expanding-HCBS states had the highest rate of spending growth, at 56.9 percent.

EXHIBIT 3
Mean Per Capita, Inflation-Adjusted Nursing Home Spending In States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005



SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.
NOTE: For explanation of types of HCBS states, see text.

EXHIBIT 4
Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending, Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, In States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005

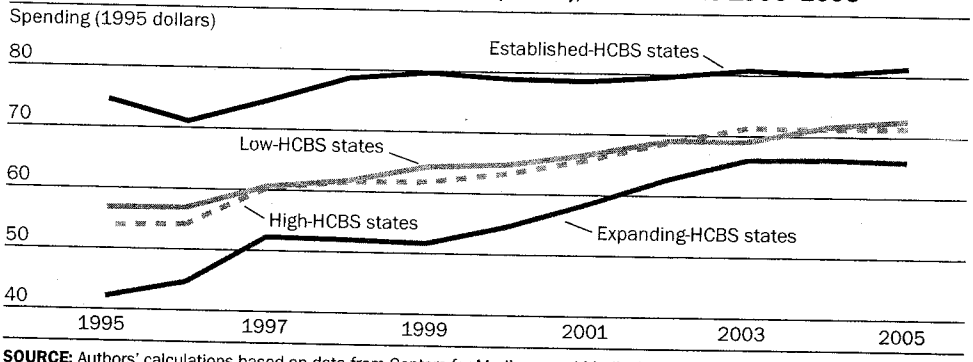


SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.
NOTE: For explanation of types of HCBS states, see text.

■ **Expenditures following HCBS expansion.** Having observed that for both non-MR/DD and MR/DD programs, established-HCBS states controlled spending better than low-HCBS states and much better than expanding-HCBS states did, we hypothesized that HCBS programs incur an initial cost and have the eventual, but not immediate, effect of reducing institutional spending and limiting the growth of overall LTC spending. To explore this possibility, we examined LTC spending before, during, and after expansion of HCBS programs in several states.

Nine states rapidly expanded their non-MR/DD HCBS spending during the latter part of the 1990s and then held that (inflation-adjusted) spending relatively steady until at least 2005. One state created a new PCS program and another ex-

EXHIBIT 5
Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending On Mental Retardation/Developmental Disability (MR/DD) Programs, In States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005



SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.
NOTE: For explanation of types of HCBS states, see text.

panded an existing program, two states created new waiver programs and four expanded existing waivers, and one state expanded both a PCS and a waiver program. The growth in HCBS spending typically occurred over two years and then leveled off.

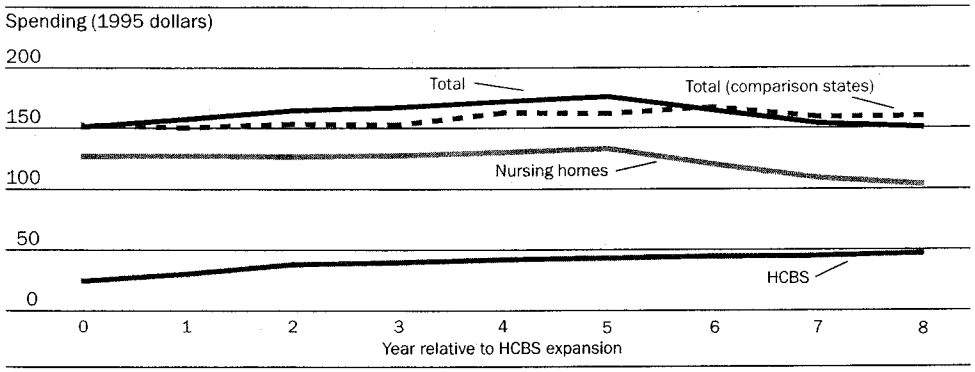
Exhibit 6 presents the mean spending on non-MR/DD HCBS, nursing homes, and total non-MR/DD LTC for the nine states; data for the states are combined not according to the fiscal year of expenditure but instead according to the year relative to the expansion. The states had not yet begun to increase spending during Year 0 (1995 for three states, 1996 for two, and 1997 for four); the expansion was essentially complete by Year 2; and HCBS spending remained relatively steady for the six subsequent years (ending in 2003, 2004, or 2005).

For these states, HCBS spending increased on average by 57.3 percent during the two years of rapid growth, and then much more slowly during subsequent years. Nursing home spending remained fairly stable for the three years following full expansion and then declined in each subsequent year. Total non-MR/DD spending rose especially rapidly during the period of HCBS expansion and then rose more slowly for the next three years. During subsequent years, however, total inflation-adjusted spending fell substantially, returning to just below its pre-expansion level in the final year.

For comparison, we identified fifteen states that held their non-MR/DD HCBS spending stable over the entire period (Exhibit 6). With flat HCBS spending and increasing nursing home spending, the comparison states saw a 4.6 percent increase in overall spending over the period. Initial levels were roughly equal in the comparison and expansionary states; following a temporary increase, the expan-

EXHIBIT 6

Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending, Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, In Nine States, Before, During, And After Home And Community-Based Services (HCBS) Expansion



SOURCE: Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.
NOTES: Expansion states are CO, CT, KS, MN, NC, NE, TX, WA, WI. Comparison states are AL, AR, DE, FL, GA, IN, KY, MI, NJ, NY, ND, RI, TN, VA, WV.

sionary states were able to reduce their overall non-MR/DD LTC spending to approximate that of the comparison states in Year 6, and then further reduce it in subsequent years to below the comparison levels.

A similar analysis of states that expanded their MR/DD spending in the late 1990s (not shown) also suggests a lag between an increase in HCBS spending and a reduction in institutional spending, but the lag period appears to be shorter than for the non-MR/DD population.

Discussion

An analysis of state-by-state Medicaid LTC spending for 1995–2005 reveals that states offering extensive noninstitutional services experienced growth in overall spending comparable to that in states offering lower levels of such services. This finding holds true for spending on services both for people with nondevelopmental physical or cognitive disabilities, on the one hand, and for people with intellectual and other developmental disabilities, on the other.

For both types of spending, states with extensive, well-established noninstitutional programs saw much less spending growth than states with minimal noninstitutional services. In the case of non-MR/DD spending, states with well-established noninstitutional programs actually reduced their overall, inflation-adjusted LTC spending, in contrast with growing expenditures among states with minimal noninstitutional services. States that greatly expanded their HCBS programs during the period, however, saw greater increases in overall spending than other states did; the bulk of this expansion occurred after 2000, and its long-term effects are not yet observable.

■ **Negligible impact of other factors.** In comparing LTC spending patterns across states, it is worth exploring whether economic or population factors might account for the observed differences. Published models of state variations in total LTC spending have identified the most important predictors as average income and proportion of the population likely to need LTC, based either on a disability measure or on the proportion of residents who are very elderly.[13] We obtained state-by-state data from the 2000 census on median household income and on the proportion of residents with self-care difficulties; we found no significant correlation between either of these variables and the proportional change in LTC spending. It is therefore unlikely that such factors could explain the different spending trends observed among the states.

■ **Lag between HCBS expansion and lower LTC spending.** An examination of a group of states that expanded HCBS programs in the late 1990s suggests that there is a lag between the expansion of noninstitutional services and a subsequent, compensatory reduction in institutional spending, resulting after several years in lower total LTC spending than in states that did not expand HCBS programs. Because HCBS programs tend to serve people at risk of needing institutional services, with the goal of deferring or obviating their eventual institutionalization, and not merely

people gradually moving out of institutions, a lag between the introduction of an HCBS program and a reduction in the institutional population might be expected. Furthermore, real savings in institutional costs occur only when the number of Medicaid-financed nursing home residents is reduced, a process that can take years.

It seems apparent that states offering noninstitutional LTC services as an alternative to institutionalization are not only complying with the *Olmstead* decision and meeting the demands of their citizens with disabilities, but are also potentially saving money. One caveat, however, is that an initial outlay is required to launch a new HCBS program, followed several years later by a reduction in institutional spending and the possibility of overall cost savings. Additionally, our results do not necessarily imply that institutional savings occur automatically, but instead may result from parallel policy initiatives such as certificate-of-need programs or moratoria on new nursing home beds.[14]

It is clear, in any case, that states offering noninstitutional alternatives do not generally suffer any long-term financial penalty as a result. Such states have been able to contain and even reduce costs, largely avoiding a feared "woodwork effect" in which the demand for services was predicted to grow tremendously once HCBS programs became available.

■ **Pending legislation and its costs.** Legislation pending before Congress would require states not already doing so to offer noninstitutional alternatives to anyone eligible for institutional services. The Community Choice Act, successor to the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA), was once estimated by the Congressional Budget Office to require additional Medicaid expenditures of $10–$20 billion or more annually, but a recent study calculates that the cost would be much lower, $1.4–$3.7 billion.[15] Neither analysis attempted to estimate cost savings through a commensurate reduction in institutional spending, however. Our study suggests that if experience is any guide, such legislation would likely entail no additional long-term spending and might in fact save money over the long run by providing less costly services to people who could then avoid or defer entering a nursing home or an ICF/MR.

FRAIL ELDERLY PEOPLE, and especially nonelderly people with various types of disabilities, need services that allow them to remain in their homes and retain their independence, and avoid entering an institution, possibly to remain there for the rest of their lives. In some states, those who cannot afford to purchase their own services have no alternatives to institutionalization. Justifications based on financial constraints can no longer be credibly offered as reasons for forcing such people into nursing homes and other institutions. HCBS programs may be one instance in which offering people greater choice also helps reduce costs.

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NOTES

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AARP℠
The power to make it better.

AARP Montana Legislative Priority

Home and Community-Based Services – Crucial Choices for Quality of Life

A recent survey of AARP members in Montana showed that 70 percent of respondents ranked remaining in their homes as a top concern. And 75 percent said that helping people age in place should be a top legislative priority.

A key priority for AARP in Montana is helping older adults to meet their long-term care needs by supporting home and community-based care. AARP Montana, in partnership with the Long Term Care Choices Coalition, is advocating for a package of improvements in the 2009 legislative session to expand the availability of long term care services and choices under the Medicaid Home and Community Based Services program. Through these efforts, we are working to assure that high quality long term care services are available to all Montanans.

What are Home and Community-based services?

Medicaid Funded Home and Community Based Services (HCBS) is a way for low-income Montanans who need nursing facility level of care to stay in their homes. HCBS include a number of programs, including: Personal Assistance Service, members of the Community Services Bureau, and Hospice Care for the terminally ill. These programs are federally matched by Medicaid funding.

Montana's HCBS are in need of improvements, and AARP and the Coalition are advocating for a package that will help hundreds of Montanans get the help they need in the environment they choose. This package includes:

- ✓ Provide services to everyone on the waiting list. 403 people said that they would take advantage of Medicaid HCBS tomorrow if it was possible. The next state budget should expand funding in the Senior and Long Term Care budget to ensure home-access to services for the people who need them.
- ✓ Increase provider rates at least 2% per year. To meet inflationary costs provider rates would need to increase 3.5%, but given a tight state budget 2% is a minimum. If provider rates do not keep pace with inflation, the quality of care will decline.

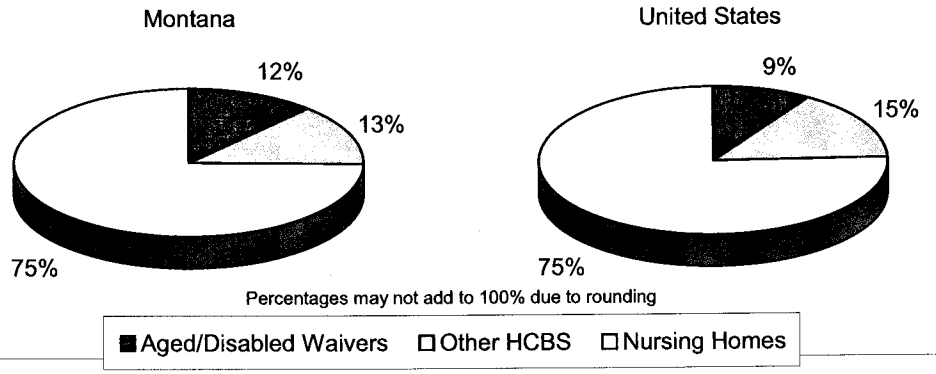
Being a direct care worker is a very difficult and demanding job. In order to keep a high quality of care for Home and Community Based Services, Montana must address workforce shortages and high turnover rates. Three simple steps will make drastic improvements in services for seniors and people with disabilities:

- Maintain new Health Care for Health Care Workers Program. To best take care of needy Montanans, we need to provide them with the best help possible. The workers themselves must be provided health care for this to happen, so continuing health insurance benefits beyond the 6-month pilot phase ending June 30, 2009 is crucial.
- Pay Increase for long term direct care workers. Providers who serve Medicaid clients cannot significantly increase these workers' wages without support from the Medicaid program. We are advocating for a wage increase of at least 75 cents an hour, and as much as $1.50/hour, by mid 2011 which help retain these highly valuable direct-care workers.
- Restore funding for Area Agencies on Aging – last legislature gave the AAA $3 million to help provide more meals and care, but the current budget was stripped of this funding.

Help ensure that Montanans have choices as they age – choices that include remaining in their own homes and remaining active in their communities. Support Home and community-based services measures in HB2.

MONTANA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Montana and the U.S., 2006



Similar to the U.S. average, Montana allocates a greater percentage (75 percent) of its Medicaid long-term care (LTC) spending for older people and adults with disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Montana spent 12 percent on waiver services and 13 percent on personal care services (PCS).

Type of Service	Medicaid Participants[1]			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	4,279	4,805	+526	$44	$49	+$5
Nursing Homes	5,549	5,204	-345	$111	$147	+$36

Although Montana still has an unbalanced LTC system for older people and adults with physical disabilities, Medicaid trends indicate that slight progress has occurred in recent years. The number of Medicaid participants receiving home and community-based services (HCBS) increased slightly, while the number of participants in nursing homes declined slightly from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than seven times as much as the increase in spending on HCBS.

[1] This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

AARP Public Policy Institute

In Brief

A Balancing Act: State Long-Term Care Reform

This In Brief examines the extent to which states have balanced the delivery of Medicaid-funded long-term services and supports to people in their homes (or in more homelike settings in their communities) and in institutions. It offers a unique focus on older people and adults with physical disabilities separate from other long-term care populations, such as people with developmental disabilities. The paper explores what states have been able to accomplish under current Medicaid law and addresses the impact of federal policies on state efforts.

Introduction

The overwhelming majority of people with disabilities age 50 and older (87 percent) want to receive long-term care (LTC) services in their own homes. People want choice and control over everyday decisions.

Yet the Medicaid program—our nation's single largest source of funding for long-term services and supports (LTSS)—does not provide the range of choices people want. Instead, it continues to allocate a disproportionate share of its resources for institutional services.

Seventy-five percent of Medicaid LTC spending for older people and adults with physical disabilities paid for institutional services in 2006.

On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based services (HCBS) for every person in a nursing home.

To the extent that states redirect resources to provide HCBS instead of nursing home services, their programs and services can be increasingly cost-effective and responsive to the preferences of people with disabilities.

Findings

- In 2006, only seven states spent 40 percent or more of their Medicaid LTC dollars for older people and adults with physical disabilities on HCBS: Alaska, California, Minnesota, New Mexico, Oregon, Texas, and Washington.
- There is great variation among states, ranging from 5 percent or less to more than 50 percent of Medicaid LTSS funds for older people and adults with disabilities going toward HCBS.
- As a whole, the nation made progress in balancing its growth of Medicaid LTC *expenditures* for older people and adults with disabilities from 2001 to 2006 by increasing HCBS spending by $6.1 billion, compared to a $6.6 billion increase for nursing home services.
- However, progress in balancing Medicaid *spending* varied greatly among states. In 22 states, the dollar increase in Medicaid spending on HCBS from FY 2001 to FY 2006 was greater than the dollar increase in spending on nursing home care. Another 27 states added more Medicaid funds to nursing home services than to HCBS during these five years.

AARP

- The nation made considerable progress by increasing the *number* of older people and adults with physical disabilities receiving HCBS, compared to the number served in nursing homes from 1999 to 2004.
- The *number* of HCBS participants increased from 1999 to 2004 in 43 states and declined in seven. In 27 states, the number of nursing home participants increased over the same period, while the number declined in 24 states.

No Magic Formula

Reforming a state's Medicaid LTSS system is a complex process that requires commitment from state officials and cooperation from federal authorities.

Positive transformational change of Medicaid's LTSS system requires a philosophy that embraces the right of people with disabilities to live in the least restrictive environment; effective leadership; a creative problem-solving attitude that can find innovative ways to work within existing laws; and innovative ways to encourage federal policy makers to waive or overturn rules that hinder states' ability to balance their service delivery in favor of HCBS.

Recommendations

The ability of some states to accomplish substantial reforms demonstrates that obstacles to change can be overcome.

Change can be accelerated and supported by adopting federal and state policies that:

- Allow consumers to receive services in the setting of their choice.
- Adopt nursing home diversion programs that prevent people from ever entering a nursing home.
- Eliminate waiting lists for HCBS.
- Offer a range of residential choices.
- Support family caregivers.
- Facilitate states' ability to establish a unified global budget for funding LTC.
- Consolidate LTC programs, policies, and budgets in one state agency.
- Put a moratorium on Medicaid regulations that hinder states' ability to help individuals leave nursing homes and transition to HCBS.
- Eliminate Medicaid's institutional bias.
- Increase affordable public and private financing options to give people more choice and control over the services they need.
- Explore offering states financial incentives to accelerate the pace of change in shifting more Medicaid spending to HCBS.

In Brief # 161, July, 2008

This In Brief is a synopsis of the AARP Public Policy Institute Research Report of the same title, number 2008-10 by:

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In Brief

Table A1:
Medicaid Long-Term Care Balancing (% HCBS)

State	Percent of 2001 Medicaid LTC Expenditures going to HCBS				Percent of 2006 Medicaid LTC Expenditures going to HCBS			
	All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities		All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Oregon	67%	1	51%	1	72%	1	55%	1
New Mexico	55%	2	34%	4	67%	2	54%	2
Washington	47%	6	42%	3	60%	4	54%	3
Alaska	54%	3	32%	7	63%	3	51%	4
California	47%	7	43%	2	51%	9	47%	5
Texas	33%	22	34%	5	40%	18	42%	6
Minnesota	40%	12	19%	17	60%	5	40%	7
North Carolina	35%	16	33%	6	41%	16	39%	8
Idaho	28%	27	26%	9	42%	14	38%	9
Kansas	43%	9	26%	10	53%	7	34%	10
Nevada	22%	35	14%	24	42%	13	32%	11
Missouri	33%	21	24%	11	39%	21	30%	12
Wisconsin	34%	17	23%	14	44%	10	27%	13
New York	32%	23	23%	13	39%	19	26%	14
Montana	38%	14	29%	8	42%	15	25%	15
Oklahoma	33%	19	15%	21	41%	17	25%	16
Maine	39%	13	13%	26	52%	8	24%	17
Dist. of Columbia	1%	50	1%	48	22%	47	23%	18
Virginia	29%	26	17%	20	36%	28	23%	19
Massachusetts	30%	24	15%	22	39%	23	22%	20
Arkansas	25%	30	23%	12	26%	40	21%	21
Colorado	46%	8	17%	19	43%	12	21%	22
New Jersey	20%	37	14%	23	34%	29	19%	23
Illinois	15%	44	10%	31	28%	35	19%	24
South Carolina	29%	25	20%	15	32%	31	18%	25
West Virginia	33%	18	19%	18	37%	25	18%	26

Table A1:
Medicaid Long-Term Care Balancing (%HCBS)

State	Percent of 2001 Medicaid Expenditures going to HCBS				Percent of 2006 Medicaid Expenditures going to HCBS			
	All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities		All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Hawaii	25%	33	13%	25	37%	26	17%	27
Ohio	13%	47	11%	29	26%	39	17%	28
Nebraska	25%	29	9%	34	33%	30	16%	29
Michigan	25%	32	12%	28	31%	34	15%	30
Louisiana	14%	46	2%	47	26%	41	15%	31
Wyoming	50%	5	0%	50	54%	6	13%	32
Iowa	16%	43	5%	42	32%	33	13%	33
New Hampshire	40%	11	9%	33	39%	22	12%	34
Maryland	24%	34	5%	40	38%	24	11%	35
Georgia	17%	42	11%	30	23%	45	11%	36
Mississippi	8%	49	8%	36	11%	49	11%	37
Rhode Island	41%	10	10%	32	44%	11	11%	38
Pennsylvania	18%	40	3%	45	27%	38	10%	39
Delaware	25%	31	8%	35	32%	32	9%	40
Florida	22%	36	7%	37	27%	37	9%	41
Connecticut	26%	28	6%	39	27%	36	8%	42
Kentucky	19%	39	12%	27	22%	46	8%	43
Alabama	17%	41	7%	38	25%	43	7%	44
South Dakota	33%	20	4%	43	36%	27	6%	45
North Dakota	20%	38	3%	44	24%	44	5%	46
Utah	38%	15	5%	41	39%	20	4%	47
Indiana	11%	48	2%	46	18%	48	2%	48
Tennessee	15%	45	1%	49	25%	42	1%	49
Arizona	*		*		*		*	
Vermont	53%	4	20%	16	*		*	
United States	29%		19%		37%		25%	

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona and Vermont. 2000 nursing home data are used instead of 2001 for Iowa, Kansas, Louisiana, Missouri, New Jersey, Oregon, and South Dakota.

* Data omitted because of lack of comparable data to the rest of the states.

Table A2:
Medicaid Long-Term Care Balancing (Expenditures)

State	Medicaid HCBS Expenditures (millions)				Medicaid Nursing Home Expenditures (millions)			
	2001	2006	Change		2001	2006	Change	
Alabama	$48	$60	+$12	+26%	$674	$839	+$165	+25%
Alaska	$33	$131	+$98	+295%	$72	$123	+$52	+72%
Arizona	*	*			*	*		
Arkansas	$111	$136	+$24	+22%	$370	$522	+$152	+41%
California	$1,923	$3,348	+$1,425	+74%	$2,598	$3,761	+$1,163	+45%
Colorado	$75	$119	+$44	+59%	$360	$462	+$102	+28%
Connecticut	$68	$112	+$43	+63%	$1,024	$1,226	+$201	+20%
Delaware	$10	$17	+$7	+67%	$111	$160	+$49	+45%
Dist. of Columbia	$2	$52	+$50	+2563%	$159	$173	+$15	+9%
Florida	$124	$230	+$106	+86%	$1,703	$2,396	+$693	+41%
Georgia	$90	$157	+$67	+74%	$760	$1,287	+$526	+69%
Hawaii	$22	$39	+$17	+76%	$148	$195	+$47	+32%
Idaho	$42	$85	+$43	+101%	$119	$137	+$18	+15%
Illinois	$170	$350	+$180	+106%	$1,500	$1,502	+$3	+0%
Indiana	$18	$32	+$14	+78%	$818	$1,289	+$472	+58%
Iowa	$24	$64	+$40	+169%	$505**	$441	-$65	-13%
Kansas	$121	$164	+$43	+35%	$349**	$321	-$27	-8%
Kentucky	$77	$62	-$15	-20%	$565	$734	+$169	+30%
Louisiana	$10	$109	+$100	+1043%	$515**	$637	+$122	+24%
Maine	$29	$78	+$48	+166%	$201	$247	+$46	+23%
Maryland	$36	$121	+$85	+237%	$697	$939	+$243	+35%
Massachusetts	$249	$475	+$226	+91%	$1,423	$1,673	+$249	+18%
Michigan	$234***	$253	+$20	+8%	$1,744	$1,448	-$296	-17%
Minnesota	$209	$566	+$358	+172%	$901	$853	-$48	-5%
Mississippi	$35	$79****	+$44	+127%	$416	$648	+$232	+56%
Missouri	$228	$320	+$92	+40%	$726**	$763	+$37	+5%
Montana	$44	$49	+$5	+11%	$111	$147	+$36	+32%

Table A2:
Medicaid Long-Term Care Balancing (Expenditures)

State	Medicaid HCBS Expenditures (millions)				Medicaid Nursing Home Expenditures (millions)			
	2001	2006	Change		2001	2006	Change	
Nebraska	$37	$67	+$29	+78%	$370	$347	-$23	-6%
Nevada	$15	$69	+$54	+372%	$92	$150	+$58	+62%
New Hampshire	$21	$38	+$17	+79%	$210	$291	+$82	+39%
New Jersey	$269	$428	+$160	+59%	$1,646**	$1,777	+$131	+8%
New Mexico	$87	$227	+$140	+161%	$166	$196	+$30	+18%
New York	$1,897	$2,496	+$599	+32%	$6,392	$6,951	+$559	+9%
North Carolina	$423	$717	+$294	+70%	$876	$1,108	+$231	+26%
North Dakota	$4	$9	+$4	+91%	$151	$168	+$16	+11%
Ohio	$281	$532	+$251	+89%	$2,313	$2,656	+$342	+15%
Oklahoma	$75	$152	+$76	+102%	$426	$455	+$29	+7%
Oregon	$255	$341	+$86	+34%	$240**	$280	+$40	+17%
Pennsylvania	$100	$440	+$340	+340%	$3,684	$3,862	+$178	+5%
Rhode Island	$27	$35	+$8	+31%	$244	$298	+$54	+22%
South Carolina	$94	$104	+$10	+11%	$374	$463	+$89	+24%
South Dakota	$4	$9	+$5	+104%	$103**	$134	+$30	+29%
Tennessee	$4	$11	+$7	+175%	$785	$943	+$158	+20%
Texas	$828	$1,301	+$473	+57%	$1,604	$1,833	+$229	+14%
Utah	$5	$6	+$2	+36%	$92	$145	+$52	+57%
Vermont	$20	*			$84	$92	+$8	+10%
Virginia	$107	$208	+$101	+95%	$528	$709	+$181	+34%
Washington	$439	$642	+$203	+46%	$614	$558	-$56	-9%
West Virginia	$68	$88	+$21	+31%	$293	$402	+$109	+37%
Wisconsin	$283	$326	+$43	+15%	$960	$876	-$84	-9%
Wyoming	$0***	$10	+$10	***	$39	$64	+$24	+62%
United States	$9,355	$15,466	+$6,111	+65%	$40,773	$47,589	+$6,815	+17%

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona and Vermont.
* Data are not included because states provide these services almost entirely through managed care programs.
** 2000 nursing home data are used instead of 2001 for Iowa, Kansas, Louisiana, Missouri, New Jersey, Oregon, and South Dakota because of irregularities in state reporting.
*** Michigan's reported expenditures for HCBS in 2001 include HCBS waiver spending for 2002 instead of 2001 because of data availability. Wyoming's waiver funding began in 2002; there were no expenditures in 2001.
**** Mississippi reported total waiver spending for 2006, but not individual waiver spending. The spending on waiver programs for older people and adults with physical disabilities uses the historical proportion of total waiver spending in the state (70%) going to this population.

Table A3:
Medicaid Long-Term Care Balancing (Participants)

State	Medicaid HCBS Participants				Medicaid Nursing Home Participants			
	1999	2004	Change		1999	2004	Change	
Alabama	6,161	8,215	+2,054	+33%	24,576	26,723	+2,147	+9%
Alaska	2,299	4,838	+2,539	+110%	929	967	+38	+4%
Arizona	*	*			*	*		
Arkansas	26,814	24,207	-2,607	-10%	20,699	28,854	+8,155	+39%
California	185,493	327,160	+141,667	+76%	117,843	119,252	+1,409	+1%
Colorado	11,481	15,425	+3,944	+34%	18,918	16,474	-2,444	-13%
Connecticut	9,176	11,335	+2,159	+24%	38,862	36,868	-1,994	-5%
Delaware	734	1,304	+570	+78%	3,109	3,736	+627	+20%
Dist. of Columbia	1,624	2,701	+1,077	+66%	4,359	6,089	+1,730	+40%
Florida	25,322	37,459	+12,137	+48%	91,985	114,134	+22,149	+24%
Georgia	14,018	15,418	+1,400	+10%	39,720	43,349	+3,629	+9%
Hawaii	923	2,043	+1,120	+121%	4,274	5,425	+1,151	+27%
Idaho	3,196	10,838	+7,642	+239%	5,014	5,075	+61	+1%
Illinois	29,783	50,279	+20,496	+69%	81,791	77,370	-4,421	-5%
Indiana	2,338	3,979	+1,641	+70%	47,988	42,952	-5,036	-10%
Iowa	3,994	8,501	+4,507	+113%	21,882	20,155	-1,727	-8%
Kansas	10,523	12,105	+1,582	+15%	17,644	17,804	+160	+1%
Kentucky	13,391	12,744	-647	-5%	27,739	26,736	-1,003	-4%
Louisiana	872	3,210	+2,338	+268%	35,508	32,306	-3,202	-9%
Maine	3,184	9,557	+6,373	+200%	9,236	9,116	-120	-1%
Maryland	4,759	8,464	+3,705	+78%	27,920	27,109	-811	-3%
Massachusetts	8,850	17,715	+8,865	+100%	60,044	60,273	+229	+0%
Michigan	49,722	64,130	+14,408	+29%	44,180	50,431	+6,251	+14%
Minnesota	18,574	34,385	+15,811	+85%	38,925	39,016	+91	+0%
Mississippi	2,667	11,747	+9,080	+340%	23,909	22,678	-1,231	-5%
Missouri	57,407	73,160	+15,753	+27%	39,762	39,606	-156	-0%
Montana	4,279	4,805	+526	+12%	5,549	5,204	-345	-6%

Table A3:
Medicaid Long-Term Care Balancing (Participants)

State	Medicaid HCBS Participants				Medicaid Nursing Home Participants			
	1999	2004	Change		1999	2004	Change	
Nebraska	3,219	6,265	+3,046	+95%	16,487	11,109	-5,378	-33%
Nevada	1,857	4,416	+2,559	+138%	3,821	4,504	+683	+18%
New Hampshire	1,489	2,510	+1,021	+69%	7,147	7,290	+143	+2%
New Jersey	24,581	25,639	+1,058	+4%	51,747	48,404	-3,343	-6%
New Mexico	1,404	12,118	+10,714	+763%	7,074	6,895	-179	-3%
New York	109,309	107,705	-1,604	-1%	139,509	200,446	+60,937	+44%
North Carolina	20,244	53,425	+33,181	+164%	42,382	43,182	+800	+2%
North Dakota	347	979	+632	+182%	5,570	5,599	+29	+1%
Ohio	26,135	34,576	+8,441	+32%	92,133	98,232	+6,099	+7%
Oklahoma	15,201	21,154	+5,953	+39%	25,758	22,917	-2,841	-11%
Oregon	27,675	31,628	+3,953	+14%	12,031	10,610	-1,421	-12%
Pennsylvania	4,411	18,912	+14,501	+329%	72,481	79,272	+6,791	+9%
Rhode Island	2,362	2,705	+343	+15%	13,297	11,754	-1,543	-12%
South Carolina	14,393	13,643	-750	-5%	17,458	17,618	+160	+1%
South Dakota	1,729	2,327	+598	+35%	5,950	5,694	-256	-4%
Tennessee	511	512	+1	+0%	37,311	35,324	-1,987	-5%
Texas	95,739	108,698	+12,959	+14%	95,812	111,437	+15,625	+16%
Utah	3,624	2,731	-893	-25%	5,513	5,403	-110	-2%
Vermont	1,014	3,331	+2,317	+229%	3,745	3,997	+252	+7%
Virginia	12,070	11,439	-631	-5%	27,746	27,902	+156	+1%
Washington	33,343	53,218	+19,875	+60%	24,620	22,555	-2,065	-8%
West Virginia	10,970	9,684	-1,286	-12%	11,788	11,534	-254	-2%
Wisconsin	24,967	32,315	+7,348	+29%	41,341	35,533	-5,808	-14%
Wyoming	982	1,356	+374	+38%	2,609	2,659	+50	+2%
United States	935,160	1,337,010	+401,850	+43%	1,615,695	1,707,572	+91,877	+6%

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona.
* Data are not included because state provides these services almost entirely through managed care programs.

Table A4:
Medicaid Nursing Home Residents on a Given Day

State	Medicaid Nursing Home Residents			
	1999	2004	Change	
Alabama	16,962	17,079	+117	+1%
Alaska	519	496	-23	-4%
Arizona	6,751	8,504	+1,753	+26%
Arkansas	15,045	13,277	-1,768	-12%
California	68,620	70,916	+2,296	+3%
Colorado	10,331	9,613	-718	-7%
Connecticut	20,353	18,226	-2,127	-10%
Delaware	1,977	2,308	+331	+17%
Dist. of Columbia	2,237	2,294	+57	+3%
Florida	44,052	44,317	+265	+1%
Georgia	28,343	27,638	-705	-2%
Hawaii	2,702	2,752	+50	+2%
Idaho	2,846	2,822	-24	-1%
Illinois	54,079	49,129	-4,950	-9%
Indiana	28,247	25,955	-2,292	-8%
Iowa	14,751	13,963	-788	-5%
Kansas	12,368	11,280	-1,088	-9%
Kentucky	17,116	15,353	-1,763	-10%
Louisiana	26,327	23,015	-3,312	-13%
Maine	5,375	4,715	-660	-12%
Maryland	12,016	15,523	+3,507	+29%
Massachusetts	36,196	31,042	-5,154	-14%
Michigan	29,145	27,717	-1,428	-5%
Minnesota	24,721	20,635	-4,086	-17%
Mississippi	13,290	12,726	-564	-4%
Missouri	25,713	23,841	-1,872	-7%
Montana	3,494	3,165	-329	-9%

Table A4:
Medicaid Nursing Home Residents on a Given Day

State	Medicaid Nursing Home Residents			
	1999	2004	Change	
Nebraska	8,100	7,274	-826	-10%
Nevada	2,469	2,598	+129	+5%
New Hampshire	4,518	4,833	+315	+7%
New Jersey	27,005	29,175	+2,170	+8%
New Mexico	4,345	4,298	-47	-1%
New York	81,352	82,920	+1,568	+2%
North Carolina	27,250	26,922	-328	-1%
North Dakota	3,504	3,324	-180	-5%
Ohio	54,854	52,490	-2,364	-4%
Oklahoma	14,738	14,057	-681	-5%
Oregon	6,527	5,099	-1,428	-22%
Pennsylvania	54,024	51,843	-2,181	-4%
Rhode Island	6,746	5,081	-1,665	-25%
South Carolina	11,402	11,462	+60	+1%
South Dakota	4,157	3,873	-284	-7%
Tennessee	25,838	22,886	-2,952	-11%
Texas	65,905	61,728	-4,177	-6%
Utah	3,425	3,143	-282	-8%
Vermont	1,956	2,224	+268	+14%
Virginia	18,301	18,119	-182	-1%
Washington	13,791	12,408	-1,383	-10%
West Virginia	7,601	7,185	-416	-5%
Wisconsin	26,359	23,117	-3,242	-12%
Wyoming	1,671	1,501	-170	-10%
United States	999,414	955,861	-43,553	-4%